

MDR Tracking Number: M5-04-2479-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-9-04.

The IRO reviewed medical necessity of office visits, manual therapy, ROM, therapeutic exercise, mechanical traction, hot/cold packs, neuromuscular stimulator, therapeutic activities, muscle testing, and muscle testing-manual.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that office visit 99213 from 8-6-03 and 8-7-03; 97140, 97110, 95851, 97750MT, 95831, 97012 and 97010 from 8-8-03 through 9-29-03 were medically necessary. The IRO concluded that all other services rendered were not medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$2780.32). Therefore, upon receipt of this Order and in accordance with **§133.308(r)(9)**, the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 2, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-4-03	A4558	\$5.76	\$0.00	G	\$5.76	Rule 134.202	Conductive paste/gel is global to procedure rendered on this date, no reimbursement is recommended.

9-11-03	97010	\$17.15	\$0.00	F	NRF		Hot/cold packs are not reimbursable per Medicare.
9-23-03	97110	\$136.20	\$0.00	F	\$35.90		See Rationale below.
9-30-03	99213	\$66.19	\$0.00	N	\$66.19		Office visit report supports billed service, reimbursement of \$66.19 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$66.19.

Rationale for 97110:

Recent review of disputes involving one-on-one CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on –one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one.” Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with Rule 134.202 and 133.307(g)(3). Therefore, reimbursement is not recommended.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-6-03 through 11-19-03 in this dispute.

This Order is hereby issued this 9th day of February, 2005.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

November 18, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

**REVISED REPORT
Decision & Rationale**

Re: Medical Dispute Resolution

MDR #: M5-04-2479-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

____ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, correspondence, physical therapy notes, FCE and radiology report.

Information provided by Respondent: correspondence and designated doctor report.

Clinical History:

This claimant was working when he was involved in an accident on ____, sustaining an injury to the lumbar spine. The claimant presented to the offices the chiropractor on 08/11/03 and was diagnosed with 722.73 intervertebral disc disorder with myelopathy, 724.9 unspecific back disorder, and 847.2 lumbar strain/sprain.

Range of motion testing from 08/11/03 revealed that the claimant had minimal restrictions in motion over the lumbar spine. Range of motion values of the lumbar spine performed on 09/29/03 were unremarkable. MR imaging of the lumbar spine performed on 10/30/03 revealed mild 2-mm broad posterior disc protrusion at L3-L4 and L4-L5 that mildly impinged the thecal sac, 2-mm disc bulge left paracentral that narrows through left lateral recess, and facet hypertrophy at L5-S1; small annular tears were noted from L3 through S1. Respective chiropractic peer review on 12/01/03 revealed that the claimant likely suffered a strain/sprain injury to the lumbar spine, and that the claimant should have no more than 21 chiropractic sessions over 7 weeks if functional improvement is documented.

Disputed Services:

Office visits, manual therapy, ROM, therapeutic exercise, mechanical traction, hot/cold packs, neuromuscular stimulator, therapeutic activities, muscle testing, and muscle testing-manual during the period of 08/06/03 through 11/19/03.

Decision:

The reviewer partially agrees with the determination of the insurance carrier as follows:

Not medically necessary:

All treatment and services rendered beyond 09/29/03 (99212, 99213, 97140, 97110, 97112, 97530, 95851, 97750-MT, 95831, 97010, 97012, E0745)

99213 from 08/08/03 - 09/25/03

E0745 from 09/02/03 - 09/04/03

Medically necessary:

99213 from 08/06/03 - 08/07/03

97140, 97110, 95851, 97750-MT, 95831, 97012 & 97010 from 08/08/03 - 09/29/03.

Rationale:

The provider has established a medically necessitated need for the implementation of rehabilitative therapeutics in the management of this claimant's medical condition.

Review of the medical records reveal full functional AROM on 09/29/03 assessment. It is at this time that a functional capacity evaluation should have been performed, and a decision should have been made on whether this employee can return to work in a restricted capacity.

The treating provider has failed to show clear rationale for the need to implement continued management in an identical therapeutic algorithm for the treatment of this claimant after functional AROM was restored on 09/29/03. MR imaging on 10/30/03 did reveal some medically significant pathology over the lumbar spine, contrary to the peer review on 12/01/03. The provider should have placed greater focus on the identification of true pain generators with an epidural steroid injection series, which could have led to a more expedited return to industry in the management of this claimant's condition.

The afore-mentioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- Jousset, N. *Effects of Functional Restoration Versus 3 Hours Per Week Physical Therapy: A Randomized Controlled Study*. Spine. 2004 Mar 1; 29 (5): 487-938; Discussion 494.
- Tacci, J. A., et al. *Clinical Practices in The Management of New Onset, Uncomplicated, Low Back Worker's Compensation Disability Claims*. Journal of Occupational and Environmental Medicine. May 1999; 41 (5): 397-404.
- *Unrelenting Low Back Pain: North American Spine Society Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*. North American Spine Society. 2000. 96p.